IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MARYLAND CERTIFIED COPY

FAYE M. GOODIE, et al., *

Plaintiff(s), * Civil Action No.:

v. * 1:10-CV-03478-RDB

THE UNITED STATES OF AMERICA, *

Defendant(s). *

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Deposition of ETHYL D. WELD, M.D.

Baltimore, Maryland

Friday, September 30, 2011

2:04 p.m.

Job No.: 1-204878

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Reported by: Rachel R. Hilker

Deposition of ETHYL WELD, M.D., held at the offices:

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Fourth Floor
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Pursuant to notice before Rachel R. Hilker, Court Reporter and Notary Public of the State of Maryland.

APPEARANCES

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EXHIBITS
(Retained by Mr. Smith)

PROCEEDINGS

ETHYL D. WELD, M.D.,
Having been duly sworn, testified as follows:
EXAMINATION BY COUNSEL FOR PLAINTIFFS
BY MR. SMITH:

Q. Doctor, could you give me your full name and your present home and business addresses?

A. Ethyl Derby Weld, 440 Grindall Street, Baltimore, Maryland, 21230. The business address would be 22 South Greene Street, Baltimore, Maryland, 21201.

Q. You are still working at the University of Maryland?

A. True.

Q. Have you ever had the misfortune of being at a deposition before?

A. No.

Q. Let me tell you a little bit about it. I'm going to be asking you questions during the deposition. Okay? You have to give verbal responses because words go into this woman's ears, and they come out her fingers, and she types all the stuff down, but

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unless we have words, it can't happen. Okay?
A. Okay.
Q. For everything to work well, I need to get my whole question out before you start your answer, and I need to let you give your whole answer before I start the next question. So if it appears that I'm interrupting your response, put your hand up to stop me.
A. Okay.
Q. I may ask questions that you don't know the answers to. If you don't know the answers to them, simply tell me. Okay?
A. Okay.
Q. I don't want you to guess or speculate. Okay?
A. Yes.
Q. If I ask a question, and you understand it, then I am assuming you are going to give the answer to it. Is that fair?
A. Yes.
Q. If you don't understand the question, which is not surprising with some of the questions I ask,

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you tell me, and I'll try to fix it so that you can answer it. Fair?
A. Yes.
Q. If we need to take breaks, just tell us.
A. Okay.
Q. Married?
A. Yes.
Q. Children yet?
A. Expecting one November 27th.
Q. The 27th, it could be a Thanksgiving child.
A. Yes.
Q. We'll celebrate with turkey.
You are a medical doctor?
A. Yes.
(Exhibit 02 was marked for identification and was retained by Mr. Smith.)
BY MR. SMITH:
Q. I have a copy of your C.V., which is dated September 22, 2011. I'm assuming that, in the past eight days, nothing has changed on this C.V., correct?
A. You are assuming correctly.
Q. What do you do at Maryland now?

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A. I'm a clinical instructor of internal medicine and pediatrics, and I work as an attending physician hospitalist in an intermediate medical care unit, which is one step down from an ICU. I occasionally attend in pediatrics on the pediatric wards teaching residents and medical students. My training is in both internal medicine and pediatrics.
Q. I had noticed, from looking at something which I don't know what it was, that you also have an interest in infectious disease?
A. Yeah. I'm a clinical fellow in infectious disease at Johns Hopkins beginning in July. You match two years before you begin, so I have that position.
Q. Do you know who you will be training with?
A. The infectious disease department.
Q. Do you know who there?
A. Dave Thomas is the chair of the department. Bartlett is the former chair. Stuart Ray is the program director. Basically, you rotate through with the entire department.
Q. So I take it, though, if I were to ask you questions regarding your education, graduate training,

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certifications, medical licensure, employment, and the like, your answers would be consistent with what's contained in your CV?
A. Yes. The only thing I'm not sure about is when I need to re-up my license. I need to fill out a form and send it in. I'm licensed as of July 2010.
Q. It says, "License expires 9-30-2011."
A. Are you serious?
Q. That's what it says.
A. That's very important to know. Thanks. I will send the form in.
Q. I wouldn't have even thought of that, but anyway, you certainly don't want to let that expire.
You are waiting to hear from the Internal Medicine Board?
A. True.
Q. You are probably glad you don't have to sit for that again.
A. I'm hoping not.
Q. At least not for another ten years. In any event, you are Board-certified in pediatrics?
A. Yes.

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Q. So your sole employer in medicine since graduating from the University of Chicago has been the University of Maryland?
A. Yes, and it's a combined program in residency between the Veterans Affairs Hospital and the University of Maryland.
Q. That, I understand, but you haven't gone anywhere else?
A. No. I went to Maryland right after graduating.
Q. The hospitals at which you have had privileges, University of Maryland, the Veterans Affairs Hospitals, anywhere else?
A. We also train at Mercy Hospital for part of our residency.
Q. Did you do training at Mercy?
A. I did.
Q. And 2006-'07, I think, is first-year residency; '07-'08, second year, '08-'09 third year; and --
A. Medicine and pediatrics has four years, so '09-'10 is the fourth.

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Q. When were you at Mercy?
A. We rotated through Mercy both for pediatrics and for internal medicine all four years.
Q. So then part of the time, who knows when, you would be at Mercy?
A. Yes.
Q. Does that mean you would go directly to Mercy and work there for a period of time?
A. Yeah. We would come to morning reports and grand rounds at the main hospital, but with that exception, we'd do most of our clinical care for that month at Mercy.
Q. Were you more than one month at Mercy for a particular time, or were there designated months? How did it work?
A. It was a smattering of months, usually not two in a row, but definitely, in total, more than one month at Mercy.
Q. It would somehow be scheduled, you'd notice it, and then you would vary your routine accordingly?
A. Yes.
Q. Other than Mercy, any other hospitals at which you rotated at all during your residency?
A. I am a founding member of a hospital ship in Africa on Lake Tanganyika, and I did a mobile clinic there for a month.
Q. When was that? What month? What year?
A. It was, I believe, the second to last year of residency in the summer months.
Q. When you say the second to last year of residency, so that would have been 2010?
A. I think so. I think so. But you know what, it might be on there.
Q. If it's on there, we'll stick with what's on there. That's fine.
This case deals with emergency medicine. Was any portion of your residency dealing with rotations through the emergency department at either the University of Maryland, Veterans Hospital, or at Mercy?
A. Yes, all of the above. We did time in the emergency room both on pediatrics and internal medicine at Maryland. Then for internal medicine, we did rotations through emergency medicine at the V.A.

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and at Maryland, not at Mercy.
Q. But never at Mercy?
A. No.
Q. Because University of Maryland does have people who are at Mercy?
A. Yeah. You know what, I have the impression it's mostly attending and moonlighting senior resident in emergency medicine staffed.
Q. Were you in emergency medicine similar to what you had told me about Mercy on particular months?
A. True.
Q. So you would find out through the residency program that on a particular month you would be rotating through the emergency department either at Maryland or at the V.A.?
A. Yes.
Q. Was it always just a month?
A. Pretty much. I seem to recall that when you were doing outpatient medicine, you would do certain selected shifts at the ECS, which is the V.A. E.R. So that would be a block that's dedicated to

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outpatient medicine, but you are filling in on a couple shifts.

Q. Do you know how many months you rotated in emergency medicine in total at any hospital?

A. I don't know. I think that I could check that answer by looking at the Am I On schedule. That's the medical scheduling software.

Q. Are you able to reasonably estimate how many months?

A. Yeah. I would say that, on the University side, you do one month as an intern and only emergency medicine in the E.R. On the V.A. side, I would say it's more like three months, two or three.

Q. So you might have done two or three months spread out over four years?

A. Of adult emergency medicine, that sounds about right. I would have to confirm the actual numbers.

Just to add, in pediatrics, the emergency room experience was more abundant because at Mercy the emergency room serves as an urgent care that a lot of people use instead of going to the clinic. So it's

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slightly lower acuity, but there is more time spent in the emergency room when you are rotating at Mercy.

Q. Since completing your residency in June of 2010, have you spent any time as an attending in the emergency room at Maryland or at the V.A.?

A. No. No, I'm not Board-certified in emergency medicine. We do that as an experience to broaden our practice of internal medicine.

Q. Is it your understanding, to be an attending either at Maryland emergency department or the V.A. emergency department, you have to be Board-certified in emergency medicine?

A. I don't know the answer to that. I know that there are only very experienced physicians that I trained with in both emergency rooms, and I don't know their Board certification.

Q. Were there particular emergency room physicians at Maryland with whom you trained when you were rotating through either the ED department at Maryland or the V.A.?

A. Yes.

Q. Who were the people that you trained with?

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A. I training with any E.R. physician that was on when I was working a shift. So I would call it a group of 30.

Q. So it could be anybody in the group?

A. True.

Q. As opposed to a particular two or three E.R. physicians?

A. That's correct. It's not like an apprenticeship where you are assigned to one person.

Q. This case deals with things that occurred in the emergency room in October of 2007. First of all, that would put you in the beginning of your second year of your residency?

A. Yes.

Q. Do you know if prior to October of 2007 you had any rotations through the emergency department either at Maryland or at the V.A.?

A. I would have because in internship you do a month of emergency medicine.

Q. And the first year is internship, right?

A. True.

Q. Since this deals with October of 2007, do

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you know whether or not you had been assigned to a month in the emergency department at the V.A. in October of 2007?

A. I would have been, if I was working there, either assigned to a month in the ECS or to shifts during an outpatient month.

Q. Do you know, though, one way or the other whether you were assigned for the month of October 2007 in the V.A., or you were just doing various shifts in the V.A.?

A. Let me clarify. When you are doing various shifts, it's up to ten to 12 shifts, so it actually amounts to a large experience over the course of the month. I don't know which it was, and that's something I can look up on the Am I On software.

Q. Is that something you can look up, tell counsel here, and he can let me know?

A. Yes.

Q. Where is the emergency department at the V.A.?

A. It's on the corner of Baltimore and Greene Streets. The entrance is now under construction, but

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the entrance is -- you go through an underpass right on that corner.

Q. Is it on the first level?

A. Yes.

Q. How is it that you would come to know your schedule, either the shifts or your monthly schedule, when you were working at the V.A.?

A. So there is a website called "amion.com." You put in a password that gets you to the department of internal medicine 's schedule, and you have your yearly schedule a year in advance, so you know what you are doing each month.

Then the chief residents in emergency medicine, perhaps two months advance, will tell you the actual hour details of the shifts you work.

Q. So let me see if I understand. You would know prior to the beginning of the year in the residency where you would be working throughout the year, but not necessarily what you would be doing. Then the chief resident would then set forth what your particular hours were for the month that you are working at somewhat in advance of that month?

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A. You would know where you would be working and what you would be doing. You would know that you would be doing emergency medicine or gastroenterology or a medicine floor month.

Q. With respect to the actual shifts in the emergency department, is it the chief resident that sets it, or is it someone in the emergency department?

A. It's the chief resident, as I recall, in combination with the attendings at both places, and they work out of shift schedule.

Q. Do you recall what the shifts were in the V.A. in '07?

A. I believe they were ten to 12-hour shifts, somewhere in there, and occasionally you would have an eight-hour shift.

Q. Do you know how many shifts there are in a particular day?

A. On a particular day, one shift.

Q. No, that's not what I meant. I meant how many shifts there are on a particular day that are filled up by various people during the course of the day. You might only have one shift, but there may be

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other people who are assigned who have other shifts, and they are a total of the number of shifts. Do you have any idea?

A. I'm sorry. Are you asking me how many shifts cover a 24-hour period?

Q. Yes.

A. I would have to look at that, but I think it's either two or three.

Q. When you were assigned to the emergency department at the V.A. for a particular month, were you the only person in residency who was assigned during that month, or were there other people as well?

A. There were many people. It was a pool of residents who shared the shift burden.

Q. Do you know how many people were assigned to particular shifts during the course of the day?

A. I don't know the exact answer, but my recollection is it was something like you would be there with three other residents, two attendings, six nurses. You know, it would be a team.

Q. It would be fair to say that you yourself were not responsible for staffing the emergency

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department?

A. No, I was not. Are you asking for scheduling the staffing?

Q. Yes.

A. Yeah, I didn't schedule the staffing.

Q. In terms of the emergency department at the V.A., were there designated areas of treatment. By that I mean, was there like an urgent care area, a chest pain area, a general area, things like that?

A. I believe that there was an area in the back that was more urgent care, and there was an area in the front closer to Greene Street that was more acute. The people would be seen outside the ER in the little triage room and triaged to one or the other areas.

Q. So there were generally two areas, as far as you know?

A. Yes.

Q. When you were assigned to work a particular shift, were you assigned a particular area to be in, or could you be in either area?

A. I think what I remember is: You were

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assigned a particular area. You were either in the front or in the back, but I think that there would be occasions where the back would be busier than the front, so someone from the front would go back and help out the back.

Q. Now, the back is urgent care, and the front is the acute?

A. Yes. I think that's right.

Q. Do you know how many beds were in each?

A. I recall around ten beds in the front, the acute area, and the urgent care area would be more like examining tables in rooms, and I think there were maybe, I'd say, eight to 15 rooms.

Oh, and then there is this middle area just behind where the residents sit that had four beds in it, which is part of the acute area. So that would make the acute area have 14 beds, I think.

Q. I take it that during any shift in which you were working as a resident, there were attendings?

A. Always.

Q. Do you know whether the number of attendings varied depending upon the time of day?

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A. I don't know.

Q. Did you consider your duties as a physician working in the emergency department at the V.A. to be any different than an attending's duties?

A. Yes.

Q. What is the difference?

A. My duties were to collect clinical data and to present it to the attending and discuss it with the attending and come up with a treatment plan. The attending's duties were to supervise residents who were doing that and verify the clinical data they had collected and come up with a plan in a teaching role.

Q. Were there ever occasions in which you were collecting data and you had to act faster than you could in terms of getting the information to the attending? In other words, you had to act before you presented the entire plan?

MR. MEDINGER: I'll object to form. You can answer.

THE WITNESS: I'm sorry. Can you say that again?

BY MR. SMITH:

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Q. Are there occasions where you had to make decisions in terms of a plan prior to your being able to present it to an attending?

A. Well, in terms of a plan that related to initial diagnostics, lab tests, radiologic tests, sometimes you would see a patient initially. The attending would be discussing another patient with another resident, and you would put in initial lab orders and diagnostics, for example, but there would never ever be a time when you discharged a patient from the emergency room without discussing the overall plan of care with the attending.

Q. In terms of there being a disposition of the patient, whether the patient was held for observation, admitted, or discharged, that wouldn't occur without conferring with an attending?

A. No, that would not occur.

Q. That's what I meant. That's what you are saying: That doesn't occur.

A. Right.

Q. So before a decision or disposition is made, you have conferred with the attending?

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A. True.

Q. I'm trying now to find out whether you had a general method, as opposed to how you did things when you were working in the E.R., from when a patient is assigned to you until disposition. Let's start with how that happens.

How did you learn that patients were assigned to you in the ED department?

A. Actually, what I remember is: You would pick up charts that were sort of on the wall in the rack. You'd pick them up in the order that they were put it in by the nurses. So sometimes that would be the order of the patient coming in, and sometimes it would be the order of acuity. I think it was something like, you know, you take the one from the top of the pile. So you would take responsibility for a patient by grabbing their chart.

Q. When you grabbed the chart -- well, first of all, what was that chart made up of at the time when you first grabbed it?

A. Gosh, this is going back three years. I'm trying to remember if it was -- in University

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Hospital, it was a clipboard with initial vitals, a T-sheet by the nurses, you know, some initial preliminary studies.

What I don't remember is whether in the V.A. it was all computerized or whether there was a clipboard. I seem to remember there was a clipboard, but the V.A.'s electronic medical records are very progressive and vast, and so it would make sense there was an electronic component, mainly for lab results. For example, the EKG is something that you would need a tangible, hard copy of, so I think they had a clipboard too.

Q. When a patient was assigned to you by your picking up the clipboard, was there anything that you reviewed prior to seeing the patient?

A. No. You would take the clipboard, and then you would look at their vitals, see if they needed to be seen immediately without you even sitting down at the computer to look at their record. Then usually I would spend some time glancing at the computer to look at -- I think the initial vitals were in the computer, but I don't remember that exact point.

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So I would make sure I knew the initial vitals and the presenting complaint. Sometimes I would have done what we all a chart biopsy, looking through the medical records before seeing them, and sometimes I would do that immediately after seeing them.

Q. By looking through, were there times that you would look through and see what was available in the computer?

A. Yes.

Q. And that may be at any time during your working with a patient?

A. Yes.

Q. Before you saw them? After you saw them?

A. Yes.

Q. And when you saw the patient, I guess you took your own history?

A. Yes.

Q. You yourself performed your own physical exam?

A. Yes.

Q. And you yourself would look at tests or studies that had already been done and would decide upon certain tests or studies that you thought needed to be done in order for you to come up with a plan?

A. Yes. I myself would, and the attending himself would, or herself.

Q. If something is ordered, that's input in the computer, or a form is filled out? Would that be correct?

A. Again, the nitty-gritty of how to order tests at the V.A. I don't totally remember. I think there was one form that you can check boxes on, and then there were some tests requiring computer orders, I think, such as radiologic tests.

Q. If it were a paper that you had to use for the order, would it contain something with your name on it that you were the one ordering?

A. I don't know.

Q. When you did something on the computer, would it be such that it would contain your name on it as the person ordering?

A. Yes, in the computer, definitely, because you have to log in, so anything that you order in the computer is tied with your name.

Q. And also the time you do it and all this other stuff?

A. True.

Q. In connection with your working up patients, do you yourself read imaging studies?

A. I usually would -- in my second year of residency, I would have deferred to the radiologists. Now I routinely read imaging studies that are simple like X-rays, and I defer to the radiologists on things like complex MRIs and angiograms.

Q. How about CTs?

A. I always review imaging studies with my own eyes, and I always discuss it with the radiologist.

Q. Because it's both a learning experience and so you understand what's going on with your patient?

A. Yeah. Exactly right. It's also that I'm not trained in radiology, but I want to look with my own eyes at whatever data there is available and also talk to the experts who have looked with their own eyes.

Q. So you can put forth the images with the

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clinical data that you have to more understand what's going on?
A. Yeah.
Q. Back in 2007, October 2007, essentially in the beginning of your second year of residency, what knowledge, generally, did you have of vascular surgery?
A. General knowledge, certainly not specialized knowledge.
Q. Did you have any knowledge as to complications that might ensue from endovascular repairs?
MR. MEDINGER: I'll object to form. You can answer.
A. I would have had the knowledge that I had gleaned as an intern working as an internal medicine and pediatrics resident and the knowledge that I would have gleaned as a medical student.
Q. Did you have a general knowledge as to why certain patients received endovascular repairs?
A. Probably I would have had the knowledge that people with atherosclerotic disease or aneurysmal

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disease would occasionally need endovascular repairs.
Q. And you would have sort of an understanding as to what bypass repairs were generally?
A. Yeah. Again, often, you know, this would be from studying in medical school and from previous experience, but I did not have training as a vascular surgeon.
Q. No. That, I understand.
A. Nor did I have expertise in vascular surgery
Q. Did you have an understanding as to what signs and symptoms you would look for as an emergency room physician for complications of someone's bypass surgery?
A. Yes.
Q. Were you aware of what tests and studies were available to you as an emergency room physician to examine whether or not someone might be suffering a complication of a bypass procedure?
A. Yes.
Q. Did you, back in October of 2007, have knowledge of complications that someone might have if

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they developed an aortoenteric fistula?
A. Did I have knowledge of what symptoms they would have?
Q. Yes.
A. Yes.
Q. And what the risks would be if they developed an aortoenteric fistula?
A. What the risk would be?
Q. Yeah.
A. The risk would be catastrophic. Yeah. The symptoms are generally sepsis and shock.
Q. Once the sentinel event occurs?
A. Yes.
Q. I don't want to know anything that you and Mr. Medinger, or someone else from the AG's office, talked about other than how to get here, but I want to know what, if anything, you reviewed in preparation for today's deposition. Did you review any records?
A. Yes.
Q. What records did you review?
A. The medical record at the V.A.
Q. So you reviewed V.A. records?

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A. Yes.
Q. Relating to Mr. Johnson?
A. True.
Q. You didn't review V.A. records relating to some other patient?
A. No.
Q. Did you review records relating to medical treatment that Mr. Johnson received at any other institution?
A. No.
Q. Did you review reports prepared by other physicians relating to their review of Mr. Johnson's care and treatment?
A. Are you talking about a retrospective review --
Q. Correct.
A. -- or at points along the continuum of his care?
Q. I have produced reports of experts. I have given them to Mr. Medinger.
A. No, I didn't review any expert reports.
MR. MEDINGER: And I'll just proffer for

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the record, just so you can know exactly what she was given, and she can answer specific questions as to what she actually looked at --

MR. SMITH: Well I'm not worried about that.

MR. MEDINGER: No, no, but I just want to make sure --

MR. SMITH: Are they the things that you produced in discovery?

MR. MEDINGER: Yes, but not everything. She was given a binder of stuff, which contained the complaint, the V.A. medical records. Tab 3 was our interrogatory and document request responses, and then Tab 4 was your expert reports. What of that she herself read, you can ask her. I'm not sure of that.

THE WITNESS: I have read none of it. I'm sorry. I've had a busy week.

BY MR. SMITH:

Q. But you looked at the V.A. reports?

A. True.

Q. Records?

A. Yes.

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Q. Did you look at any imaging studies?

A. No.

Q. You looked at reports of imaging studies, but you didn't look at any imaging studies?

A. No.

Q. Normally, I ask you whether you looked at any depositions, but I think this is the first deposition in the case.

Have you had discussions with other people at the University of Maryland regarding this case?

A. I discussed the case with Dr. Flanigan, who was the attending.

Q. Did you discuss the case with Dr. Flanigan in preparation for today's deposition?

A. No. No. I discussed the case just to --

Q. Way back then?

A. Back then when I first heard that this case had come up to review the decisions made in this patient's care.

Q. Did you make any notes of your discussions with Dr. Flanigan?

A. No, and nor do I recall details of them.

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Q. Do you know a nurse by the name of Karen Hall?

A. That sounds vaguely familiar, but I can't put a face to that name.

Q. And it would be fair to say that haven't had discussions with Karen Hall about this case?

A. It would be definitely fair to say.

Q. There is another doctor who was involved with Mr. Johnson's care whose name is Comfort Onyiah, I think, O-n-y-i-a-h. Have you had any discussions with her about this case?

A. I have not.

Q. Have you yourself done any independent research regarding any of the issues that you see that are related to this case in preparation for your deposition?

A. I myself have done independent research relating to this case to address the case, think about the case, and think about this deposition.

Q. What have you researched?

A. I researched the epidemiology of aortoenteric fistula; the prevalence in those patients

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with endovascular repair; the prevalence of various conditions among patients who present to emergency rooms with flank pain, nausea, and vomiting; the prevalence of iron deficiency in a population of alcoholics, cocaine users, and malnourished individuals who are intermittently homeless; and some particulars relating to measurement of hematocrit and hemoglobin.

Q. As a result of that, did you accumulate any hard copies of materials?

A. No.

Q. Is this something that you are able to review simply either by looking at books or by looking on the computer in today's Internet world?

A. It is. Electronically, you can get any article you'd like through the library at Maryland.

Q. Do you remember the names of any of the articles which you reviewed?

A. So they would have been articles that are obtainable by -- via something as simple as Google Scholar by typing in epidemiology of aortoenteric fistula.

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There is one that I do remember in particular that an attending I worked with referred me to way before any of this happened about hematocrit levels and a phenomenon called postural pseudoanemia, which is written by a fellow by the name of Jacob in the Mayo Clinic proceedings May of 2008.

Q. Postural pseudo --

A. Psuedoanemia.

Q. What is postural pseudoanemia?

A. It just describes the phenomenon of blood measurements, red blood cell count measurements, hemoglobin, hematocrit depend on posture, hydration status, blood volume, many things like that. This particular phenomenon is describing what happens when a patient goes from an upright to a supine position and then hematocrit can drop up to four points because of hydrostatic pressure changes in the legs.

Q. Based on your review of the records for Mr. Johnson, do you think that his hematocrit level was decreased because of his posture?

A. Based on my review, I think that the difference between the hematocrit levels on October

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5th and October 8th, 9th, are within the range of either laboratory error or hydration or postural change.

Q. How about the difference in his hematocrit in of October 2007 and his hematocrit in January of 2006?

A. So the two-year difference in hematocrit could be explained by many different phenomena including malnutrition, iron deficiency, and several other things. Two years is too big a span to quantify an acute drop.

Q. Is it your understanding of -- even though we haven't gotten to Mr. Johnson yet -- Mr. Johnson is that he was an alcoholic?

A. My understanding, having reviewed the record, is that he was intermittently drinking to the point of intoxication, in addition to using cocaine. That's what's documented, at least, through the V.A. records.

Q. Do you have any understanding as to when the last time is that he was drinking alcohol or using cocaine?

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A. I believe that we reviewed records relating to that. I would have to check the records to look at the dates on those.

Q. How close to 2007 are we talking about?

A. Do you want me to check the records to make sure it's here?

Q. Sure. The records are there.

A. Let's see. There's a note.

Q. When you get to the page you are at, tell me you are there, and then I'll ask you -- tell you how I want you to identify the page.

A. So the front is labs, and these are clinical notes.

Q. Those are discharge summaries. Then you have consult requests. Then you have progress notes. It's very weird how they put the things together.

A. Can you remind me whether it's in reverse or advance chronological order?

MR. MEDINGER: It's in reverse.

THE WITNESS: So this discharge summary, so cocaine use, 15-30 pack/year smoker, discharge summaries, consult requests. So it would be progress

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notes.

BY MR. SMITH:

Q. Why don't you look at -- what I'm looking at is a progress note that says Page 65 at the bottom where it actually says what the substance abuse history is.

A. "History of 25 years of alcohol abuse with some use of cocaine and heroin; 18 months of recovery, with the exception of a slip when he drank two beers on 9-8-07. No drugs since '04. One previous treatment MCVET in '96." Where is the one where he said he was amazed at how many drugs he was doing and how much alcohol he was doing?

Q. I haven't the faintest idea.

A. Let's see. He went to a gambling counseling meeting.

Q. You have to tell me what page you are on.

MR. MEDINGER: Just for the record, if you can mention what page you are looking at when you just talk about that. It's on the bottom, right-hand corner.

THE WITNESS: The gambling is 62, and that

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was from October 3, 2007 at D000062. Focus on compulsive gambling as it may arise in recovery.
BY MR. SMITH:
Q. That's what the group is discussing. Does it say anything about him?
A. Not in this note. He attended this counseling group.
Then let's see, "Treat for addiction with routine MCVET and resources."
Q. Can you say what page you are on?
A. That is D000068. "Interested and willing to participate in V.A. psychiatric for substance abuse treatment." That's 2007. "How long have you been homeless?"
"Six months, but less than one year," and I think that nutrition is difficult when you are homeless.
Q. So you understand him saying homeless to mean he didn't have a place to live?
A. Well, it says, "Where did you sleep last night?"
"Shelter, temporary housing program." I

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believe he was at MCVETS. That is a shelter that is just for veterans. Then he is often at someone else's apartment or a shelter for the homeless, including detox centers with no medical staff on site. That was four nights that he spent there.
MR. MEDINGER: Doctor, just for the record, which page are we looking at there?
MR. SMITH: She is looking at Page 70.
THE WITNESS: Seventy, D00 --
MR. SMITH: You can just say Page 70. You don't have to go through all those zeros. They match up.
THE WITNESS: On Page D000071, "Do you have a problem with alcohol dependency now?"
"Yes."
"During the past 30 days, how many days would you say that you used any alcohol at all?"
"Two."
"During the past 30 days, how many days would you say that you drank to intoxication?"
"Two."
"Do you have a problem with drug dependency

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now?"
"Yes."
"Have you in the past?"
"Yes." So those all support drug and alcohol use, in my opinion.
BY MR. SMITH:
Q. Just looking at the record, they support it? Okay. I just want to make sure that's what you're saying.
A. Yes.
And again, Page 72 again, "Alcohol abuse/dependency: Yes. Drug abuse dependency: Yes."
Q. I don't know who the government's experts are yet, so I can't ask you whether you know them. There are various people who I have. This one person by the name of Kenneth Larson is an emergency room expert. Do you know Dr. Larson?
A. No.
Q. There is another internal medicine doctor, but who's also an emergency room expert whose name is Gary Witman. Do you know Gary Witman?
A. No.

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Q. There is a radiologist, who at one time was at the University of Maryland, but is not there anymore, whose name is Larry Holder. Do you know Dr. Holder?
A. I don't.
Q. And then there is a doctor whose first name, unfortunately, I keep forgetting. His name is Skudder. He is from Massachusetts. Do you know a Dr. Skudder?
A. No.
Q. He is a vascular surgeon.
A. Okay.
(Exhibit 01 was marked for identification and was retained by Mr. Smith.)
BY MR. SMITH:
Q. What I'm going to do -- you can put those away -- I'm going to hand you instead Exhibit 1, which is an excerpt of those that primarily relate to care involving you and other people in and around this time. When we talk about pages, you really just have to read those page numbers at the bottom. We'll get to them at a certain point in time.

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The records show that the care in this case on October the 9th occurred from about 1:00 or 2:00 in the afternoon until close to midnight. The first note that we have of yours is timed at like 18-something or other. Do you know what shift you were working that day?

A. It would have been the shift that put me in the emergency room at 1800, but beyond that, I do not know without looking at Up To Date -- sorry, not Up To Date, Am I On.

Q. If it shows that you were still doing stuff in the emergency room with respect to him at like 2350, would that assist you in any way as to what shift you were working?

A. Again, I don't remember the exact shift hours. I know my shifts now are from 8:00 a.m. To 8:00 p.m., and I don't remember the times of the shifts at the V.A. in 2007, so I would have to look at Am I On.

Q. Do you have any idea as to what area in the ED you were working that day?

A. I probably would have been working in the

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front.

Q. You say probably, but you don't know?

A. I don't know.

Q. Well, you are better off saying you don't know if you don't know.

A. Okay. I don't know.

Q. Do you have any idea as to how many patients in the emergency department you saw that day?

A. I don't know.

Q. Do you have any independent recollection as to how busy the emergency department was on October 9, 2007?

A. No.

Q. Do you yourself have any independent recollection of Maurice Johnson?

A. None.

Q. Is the only thing you can tell me about Maurice Johnson what you can see from looking at the records?

A. True.

Q. Have you looked at the records and then been able to recall additional things about Maurice Johnson that are not contained within the records?

A. No.

Q. Do you have any idea whether, at any time prior to October 9th, you ever saw Mr. Johnson?

A. No.

Q. Looking at the records, is there any way you can tell when the last time you spoke with him was?

A. No. Well, the last time I spoke with him would have been the day I saw him.

Q. But when during the day, we don't know.

A. Probably prior to discharge. We don't know.

Q. From your looking at the records, were you able to say what other records you accessed that day to assist you in the care of Mr. Johnson?

A. From looking at these records, am I able to say what records I viewed the day I took care of him?

Q. Yeah.

A. No.

Q. The fact that you knew that he had the bypass surgery before, do you know whether you accessed any of his records relating to that admission?

A. So when a patient comes in at the V.A., they actually have a problem list that comes up right under their name. So without reviewing any records, you would know that he had an endovascular graft, and usually that problem list is expansive. In other words, anything he has ever come in for is usually on that, a hangnail, an aortoenteric graft.

Q. Could you access that and find out more about that particular procedure for him?

A. Yes.

Q. Do you know whether you did that?

A. My general practice is to look into the relevant medical history in the V.A. I would say that, with patients who have been served by the V.A. for 20 or 30 years, it is impossible to do a complete review of the record --

Q. No. That, I understand.

A. -- every time you see someone in the emergency room, but I would say that I consider it necessary to review relevant past medical history.

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Q. He had been there the day before, a couple days before. He was there on October the 5th in the emergency department. Do you know whether you accessed the records from his October the 5th visit?
A. Am I correct in thinking that was actually a primary care visit, October the 5th, when he saw Dr. Onyiah?
Q. No. I think it was an E.R. visit.
A. So I probably would have seen that visit and the lab work relating to that because the lab work definitely comes up when you pull up the patient, when you trend the lab values over time.
I believe that was a visit for knee pain, having reviewed the records.
Q. If you turn to Page 53, let me know when you are there.
A. I'm there.
Q. Halfway down, there is the beginning of a note for October the 9th at 1859, and then it says, "Author," and it lists Weld, Ethyl Derby. Is that you?
A. Yes.

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Q. Just looking at this note, the 1859, what does that relate to?
A. That probably would have been when I opened up his ECS emergency department note template and started typing into it.
Q. Then a little further down, do you see where it says, "Time seen," and then it says 7:10 p.m.?
A. Yes, so perhaps I would have reviewed his problem list and presenting vitals before going to see him, or I got the time wrong.
Q. I'm just trying to find out what the numbers relate to because I'm sure the computer puts them there.
A. So the 7:10 would be something I would type in, so if someone's watch is fast or something, it could --
Q. I'm not worried, but is it your understanding that on your dated note, the date and time are put in automatically by the computer when you access it?
A. Yeah, I think that's right.

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Q. And the author automatically puts in there because it knows that you are the author because you have to input information?
A. Because I have opened the note.
Q. And you have reviewed these records before. Is this your only note with respect -- it goes pretty long, but is this the only note that you put in the progress notes?
A. I believe so.
Q. If you go to Page 55, there is a nursing triage note. Do you see that?
A. Yes.
Q. And that's by Karen Hall at 1550. Do you know if you would have viewed this note prior to your seeing Mr. Johnson?
A. I don't know, but likely I would have seen it.
Q. Would it have been your practice to review these notes?
A. Yeah, because there she has his vitals. Like I said, the thing I would review first is vitals in any emergency room patient.

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Q. At least in her note, if you look at the Karen Hall note on Page 56, it indicates, at least by that time, an EKG had been done?
A. Yes.
Q. If an EKG had been done, would that have been something you had looked at?
A. Yeah, and not remembering the case, I don't know if I can say the clipboard contained an EKG, but you the routine of the emergency room would be for the triage nurse to take vitals, take an EKG, put that, I believe, on a clipboard, and then draw the patient to your attention so you review that.
Q. Based on your understanding, when would they order EKGs for patients who came to the emergency room?
A. When would physicians order them?
Q. Yeah. Was it routinely they were automatically done with certain patients?
A. At the V.A., often they were routinely done without a physician ordering them.
Q. If a person came with foot pain, would they get an EKG?

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A. Sometimes. Probably not always.
Q. If a person came with any type of pain that might be understood as chest pain, would you expect them to get an EKG?
A. Yeah. Yeah.
Q. And after your note, there is a note that begins at Page 50 by someone named Audrey Pinnock. Do you know Audrey Pinnock?
A. No. I assume she is a nurse, or -- I don't know her.
Q. It appears to be a nursing flow note. But is it your understanding, for instance, under her note they have temperature, pulse, respiration, blood pressure, and next to each entry, there is a date and a time, so those would indicate when those vital signs were taken?
A. Yes.
Q. And the fact that vital signs were taken at 1543 would seem to indicate that the patient was at the V.A. hospital at least at 1543?
A. Yes.
Q. Do you have any understanding, sitting here

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today, as to why a patient who was in the emergency department at 1543 wasn't seen by you until 7:00 p.m. that night?
MR. MEDINGER: Objection. You can answer.
A. I would call that -- if you surveyed all the emergency rooms in the country, I would say that may be in line with the amount of time the typical acute patient would wait, again, with certain measures such as triaging them, making sure who the unstable patients were, stabilizing the unstable patients, et cetera, but I think everyone knows that there are sometimes lengthy waits in emergency rooms.
Q. Well, regardless of what happens in other emergency rooms, I'm trying to find out whether you know why it is that for a person who came in at around 1533, because that's when the EKG was, wasn't seen by you until 1859 or thereafter, which is about three and a half hours later.
MR. MEDINGER: Objection. Asked and answered and argumentative. You can go ahead.
A. Do I have an understanding of the reasons?
Q. I am just trying to find out if you know

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why. If you don't know why, that's fine; just say you don't know why.
A. I think the answers underpinning that are a complex series of operational, administrative, and practical reasons relating to demand on emergency rooms based on our current medical system and working to the utmost within the current parameters of care.
Q. But on October the 9th of 2007, do you recall what the staffing in the emergency department was that day?
A. I don't.
Q. And do you recall the number of patients who were being treated in the emergency department that day?
A. No, I don't.
Q. Do you have any idea what day of the week it was?
A. No. But having been a patient in many other emergency rooms, I would say that the wait time between 4:00 p.m. and 7:00 p.m. is actually relatively short, actually having been a patient with abdominal pain in many emergency rooms, just to speculate.

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Q. Your note again, which is on Page 53, the one that says HPI, that's the history that you took from the patient?
A. History of present illness.
Q. But it's the history that you took?
A. Yes.
Q. As opposed to the history you got some someone else?
A. True.
Q. That's all I was trying to find out.
Where you have, "Denies," and you have all these things that denies, was that in the part of also reviewing systems?
A. Yes, and review of systems can be part of your HPI.
Which page are you on?
Q. Fifty-three, which is where your note is.
You specifically put in the past medical history of vascular disease status post aortofemoral bypass, correct?
A. True.
Q. And, at least from your talking with him,

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that he occasionally smokes cigarettes, but didn't drink alcohol or illicit drugs?
A. No, that's -- what I would have written is what the patient reported to me.
Q. That's what I understand. You are taking the history. You are asking the patient questions, and the patient says to you he occasionally smokes, he doesn't drink alcohol, and he doesn't do drugs. He had no known drug allergies?
A. True.
Q. If you look at 54, Page 54, which is the next page, that sets forth your physical exam?
A. Yes.
Q. In terms of -- I just want to know how it works. In terms of the vital signs, when you are putting that in the computer, do you just -- does that come up automatically, or do you type it in?
A. The vital signs would populate automatically with the most recently measured vital signs entered by a nurse.
Q. Then under that it says, "General," and it says, "Mild distress. Shifting in chair. Thin."

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What do you mean when you write mild distress?
A. When someone has back pain, they might have a grimace. They might sort of have difficulty getting comfortable in a chair. That's what I would mean.
Q. So he didn't look comfortable to you?
A. Right.
Q. Underneath that, where we have HEENT, then cardiovascular, lungs, et cetera, that sets forth your physical exam?
A. Yes.
Q. And you performed a rectal exam?
A. Yes.
Q. And that was heme-positive?
A. True.
Q. And you did a neuro exam, skin, and then you ordered various lab tests?
A. Yes.
Q. ECG, he already had the EKG, and this shows that you reviewed it. It showed normal sinus rhythm, no ST wave changes?
A. No ST elevations or T-Wave changes.
Q. And then you ordered a CT for him without

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contrast because that was the renal stone protocol?
A. Yes.
Q. Tell me why it is that you ordered a CT without contrast for a renal stone protocol?
A. This is a patient coming into the emergency room complaining of flank pain, vomiting, difficulty getting comfortable in a chair. All of that is very classic clinically for a renal stone, and I felt it was reasonable to rule it out.
Q. Was it very classic for a problem with the bypass graft?
A. No. Back pain would not be classic for a problem with a bypass graft.
Q. By this time, had you -- no, you hadn't got the labs yet because you ordered the labs.
A. Yes.
Q. Do you know whether you had the lab results before you referred him for the CT?
A. I don't know that. No, actually, I would have, excuse me, because I would need to know if his creatinine was okay before ordering a CT of any kind.
Q. Why don't we turn to Page 3 because Page 3

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has lab results. This is a weird way that they print out their records.
Do you know if you went on the computer to look at lab results you would see a page similar to this where it would have essentially all the blood work that had been done the prior times he had been to the V.A.?
A. I don't know the answer to that. I don't know what the typical range that's drawn up is. I don't know whether it covers two years or 18 months. I don't know what --
Q. But do you recall, when you looked up on the screen, you saw more than just what you had ordered?
A. Well, I usually for sure see the lab result from today and the most proximal other lab result that was drawn, so the baseline, in other words.
Q. If we look at the blood results, the blood test results for 10-09, which is the date we are dealing with, it lists a time of 2025. Would that be the time that it was input into the computer?
MR. MEDINGER: Objection. You can answer

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if you know.
A. I don't know the answer. I don't know the particulars of the computer V.A system, but I would speculate that that's probably the time the labs were resulted.
Q. I'm just trying to find out if you know. I mean, if you don't know, you don't know.
A. I don't know.
Q. You don't know whether that was the time the blood was drawn, or the time it was received, or the time the results were ready?
A. Or the time this profile was pulled up or what.
Q. Well, if you see, there are other results for other days, and they all have times next to them. So if it were for the time you pulled it up, I wouldn't imagine it would have different times.
A. Again, I don't know, but I don't know whether it's resulted, drawn, et cetera.
Q. And you haven't been in the V.A. --
A. For three years.
Q. -- for a while.

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Well, you were there after 2007?
A. So I have been working as an attending for a year and a half, and I did not do any V.A. rotations in my last year of residency. I was serving as a chief, so that would put us at two and a half or three years.
Q. The last time you were there might have been '08?
A. Yeah, or '09 maybe.
Q. Page 1, that's the CT results?
A. Yes.
Q. Would I be correct that you would have seen the report prior to your coming to a plan of discharging the patient?
A. Yes.
Q. Up at the very top it says, "Exam date," and it has October 9, 2007, and it says at 1957. Do you know if that's the time the CT was done or the time it was reported?
A. Or the time it was ordered. I don't know.
Q. Do you know if you had any discussions with any radiologists regarding this report?

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A. I don't know the answer to that.
Q. Do you know why CTs without contrast are part of the renal stone protocol as opposed to CTs with contrast?
A. If you give contrast, the ureter opacifies, so you are not able to see the little bright white opacification of the stone.
Q. Okay, which makes sense.
Am I correct that, based on at least the report, there was no evidence of intrarenal or urethral calculi?
A. True.
Q. That there was -- a graft was noted?
A. True.
Q. But the radiologist is telling you he or she can't tell you anything about it because of the lack of contrast?
MR. MEDINGER: Objection. You can answer.
A. I can read you what the report says.
Q. Isn't that what it says?
MR. MEDINGER: Objection.
A. "Evaluation of this graft is somewhat

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limited, secondary to the lack of intravenous contrast.
Q. Do you have any understanding, sitting here today, why, if you were trying to evaluate the graft, you would want to have contrast as opposed to non-contrast?
A. I do understand contrast to be better for measuring extravasation of contrast when looking for vascular defects, which is a complication occurring in .4 percent of these patients.
Q. And that's based on something you've just reviewed, right, the .4 percent?
A. Yes, and based on understanding that this is a rare complication.
Q. And it's a complication that most typically occurs about six years after the procedure has been done?
A. In the data that I have reviewed, the earliest it's occurred is two days after the procedure. The mean is two days to two years, and the latest is 27 years, so it's quite a wide spread, and it being a rare event, it's difficult to comment

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beyond that.
Q. But while it's a rare event, it's a life-threatening event?
A. Is an aortoenteric fistula a life-threatening event? Yes.
Q. And so that would be something that you, as an emergency room physician, had it been in your differential, would be something you would want to rule out before you discharge the patient?
MR. MEDINGER: Objection. You can answer.
A. The rare, life-threatening events are important to consider when evaluating patients. The patient who presents to the emergency room with back pain and vomiting, and back pain that was resolved to a one out of ten after a single dose of non-narcotic medication is probably not the highest on my list for considering this rare complication. It is true that the role of emergency rooms is to establish that the patients are stable and hook them into the right care for a definitive diagnosis.
Q. So my question is: If a life-threatening event is within your differential, you want to rule it

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out before disposition of a patient?
MR. MEDINGER: Objection. Asked and answered. You can go again.
MR. SMITH: Well, it wasn't answered. It was just a self-serving statement.
BY MR. SMITH:
Q. So I'm trying to find out whether, if a life-threatening event is within your differential, you'll want to rule it out before discharging the patient.
MR. MEDINGER: Same objection.
A. Ruling out all life-threatening and rare complications in one emergency room visit is impossible. So it would be possible to pan scan a patient from head to toe, which I would argue is not correct care because that overdiagnosticates. You have to work appropriately within the limits of your skilled evaluation, history, physical exam, and the data you have available to you to understand the likelihood of various items on your differential diagnosis, and then you rule them out or arrange appropriate follow-up accordingly.

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Q. So it's my understand -- back up for a minute.
Did you have aortoenteric fistula within your differential with this patient?
A. I'm not remembering the day of seeing that patient. I don't know the answer to that.
Q. Would you agree with me that if it was within your differential, it would be something that you would want to rule out before discharging the patient?
MR. MEDINGER: Same objection. You can answer again.
A. Generally, that complication is something you could evaluate with imaging, but you could also evaluate with endoscopy set up through a GI physician, which was follow-up that I arranged.
Q. Assuming the person gets to the GI physician prior to the sentinel event, or the herald event, should I say?
A. Yes.
Q. Do you know, by looking at the records today, whether you gave any consideration to the

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symptoms that he had on the fifth, which you note are knee pain and numbness below the knees?
A. From looking at my note on Page 53, I did not mention his knee pain when he saw Comfort on the fifth.
Q. Can we agree that Mr. Johnson, on the 9th, had back pain and abdominal pain?
A. Yes.
Q. Can we agree that his hematocrit was lower than it was in 2006?
A. Yes.
Q. And it was lower than it was four days earlier, but it's one that you don't think is a substantial drop?
A. We cannot agree that this is a significant drop.
Q. Well, I said it's lower, but you don't agree that it's a significant drop.
A. What I would say is that we actually have evidence that there has not been acute bleeding in the past five days because his hemoglobin is what I would characterize as stable.

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Q. Based on your history you took from him, he had either blood in the stool or a blackened stool at least once in the week prior?
A. And normal stools since then. Correct.
Q. And he was anemic, and he was in pain?
A. True.
Q. Based on the stone survey, there was no evidence of renal calculi. We've already talked about that. No evidence of any abnormality of the urogenital collection system?
A. True.
Q. He had a normal urinalysis? That's in the labs.
A. What page?
Q. The labs are like Pages 3 and 4.
A. He had a completely -- let's see. Urinalysis showing 1+ leuk esterase, which is a measure, occasionally, of inflammation, but it's fairly nonspecific. He had one to two white blood cells, no red blood cells, no bacteria. So aside from the mild inflammation in leukocyte esterase, his urinalysis was normal, and there was no evidence of a

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urinary tract infection.
Q. He was in persistent pain?
A. He was not. His pain resolved with one dose of Toradol.
Q. Resolved?
A. To one out of ten. I have more pain than that right now.
Q. And a history of nausea with vomiting?
A. Yes.
Q. Now, your diagnosis was suspected gastritis?
A. Yes.
Q. And what are the signs and symptoms of gastritis?
A. It can be nausea and vomiting. Occasionally, you can have some GI irritation resulting in hemoccult positive stools, and you can have nonspecific epigastric pain, occasionally radiating to back. It really varies based on the patient.
Q. Sometimes people with gastritis have no symptoms?

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A. If you are asking whether endoscopies of people who are asymptomatic occasionally reveal endoscopic evidence of gastritis, I think the answer is yes.
Q. If they were nonsymptomatic, they probably wouldn't be coming to the emergency room for problems.
A. You would be surprised though. There is lots of overdiagnosticating in terms of doing endoscopies and doing diagnostic tests.
Q. Now, you prescribed the Tylenol for pain?
A. Yes.
Q. And the omeprazole?
A. Omeprazole.
Q. That was for the gastritis?
A. Yes.
Q. Normally for gastric reflux? It's one of the primary things it's good for?
A. Yeah. It's basically stomach protecting and decreasing of acid secretion, which irritates preexisting gastritis that can be brought on by alcohol, aspirin use.
Q. Now, if you look at your note on Page 54 --

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actually, I haven't gone far enough, Page 55. At the very -- near the very bottom it says, "I," and it puts your name in, so I am assuming that this comes up automatically, and then you input your name?
A. Yes.
Q. And who inputs the name of the attending?
A. Me.
Q. This is not timed. Do you know when you discussed the treatment plan and diagnosis with Dr. Flanigan?
A. I don't know.
Q. Is Dr. Flanigan still at Maryland?
A. I don't know the answer to that.
Q. When is the last time you saw him?
A. It would have been 2008.
Q. And you signed your note shortly before midnight that night?
A. Yes.
Q. And it shows here that Dr. Flanigan co-signed this note nine days later?
A. It does seem to show that.
Q. Do you know whether, sitting here today,

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you had your discussion with Dr. Flanigan before or after Mr. Johnson left?

A. I would have had it before he left.

Q. Do you know what, if anything, you told Dr. Flanigan?

A. During our discussion about the patient?

Q. Yes.

A. Are you are talking about the day the patient came in?

Q. Well, I'm talking about, "I have discussed the treatment plan and diagnosis with the attending, Dr. Flanigan." So I'm trying to find out if you recall anything about your discussion with him.

A. Yes. So I would have presented to him.

Q. Do you recall anything about your discussion?

A. No. Again, I don't remember this day or this patient, but I would have discussed with him and presented to him my clinical findings, the data at hand, and my plan. He would have had the opportunity to ask any questions of clarification, and we would have come up with a plan together.

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Q. Knowing how things work at the V.A., do you have any understanding as to why it took him nine days to co-sign?

MR. MEDINGER: Objection. You can answer if you know.

A. I don't know, but this would be an electronic co-signature. It's simply a form that he signs in the computer, not necessarily representing when we had the discussion.

Q. Do you recall hearing at all about Mr. Johnson's death?

A. When I was told by the risk management people at the V.A. that this case was happening, but that's the only time.

Q. This is the first time you heard about it?

A. True.

Q. There is a section in here called Consults, which is -- turn to Page -- I believe it's 33.

A. Thirty-three?

Q. Actually, it's Page 32.

I take it that you had to fill out a form for the GI consult?

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A. Yes. I believe that's how it's done. You put in a computer order for a consult.

Q. Let me just go through this, because I just want to get an idea. You are listed as the requesting provider, and it says, "Services to be rendered on an outpatient basis." Is that something you decide or someone else decides?

A. So that's part of the disposition plan, so it's part of my discussion with Dr. Flanigan: Does he need an inpatient scope or an outpatient scope? After our discussion, I would have put in an outpatient service or an inpatient service. Actually, if it's an inpatient scope, I wouldn't order it. The patient would be admitted, and GI would be called.

Q. So essentially, Mr. Johnson would have to go to the GI clinic to get this done?

A. Yes.

Q. Down below that it has collection data. It has the blood down there. Did you input this information, or does the computer input this information?

A. I would have selected which labs I would

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like to have input, and I believe that they are populated by the computer. You know what, "I don't know the answer," is the truth. I don't know whether it automatically populates with iron values, ferritin, pro time, PTT, and hematocrit when you order a GI consult. I don't know the answer to that.

Q. It has no data available for certain things, so that's what's leading you to think that maybe the computer automatically searches for it?

A. Maybe.

Q. Probably when anybody gets a GI consult, it may try to grab a whole bunch of different type of information and try to put it in?

A. That could be, and it also could be the case that I had to select which labs should be input. I frankly don't know the answer.

Q. And the section at the very bottom, it says, "Abdominal pain," and then, "Describe reasons for referral." That's information that you input?

A. Yes.

Q. So epigastric abdominal pain, vomiting, hemoccult positive stool, and melena times one?

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A. True.
Q. Carrying over to the next page, do you know if this is information that you do, or this is information ultimately the computer does itself, where it has -- it appears to have -- when the order was done, which is 2135? Then underneath it has, "Scheduled." Do you know how all that works?
A. I don't know how that works.
Q. Do you know if, at the time Mr. Johnson was leaving, he knew that a GI consult was scheduled for the afternoon of October the 12th?
A. So what I would have said to him when discharging him is: You need to follow up with the GI; I have made the consult. Then I'd let it administratively unfold from there and specify that it needs to happen within a week.
Q. I'm looking here. It says, "Scheduled 10-12-07, 1613: Lloyd, Ralph H." Do you know what that relates to?
A. No. I don't know how these things are scheduled in the V.A.
Q. It says, "Offer letter sent to GI New

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Fellows clinic." Do you know what that means?
A. I assume it means that they sent him a letter to set up an appointment for the GI clinic.
Q. So it's your understanding that, essentially, you are saying, "You need to schedule a GI. I'll let them know, but you are the one who has to call up and get the appointment"?
MR. MEDINGER: Objection. You can answer.
A. Let's see. In my note, "D.C. home with GI outpatient follow-up. Given telephone number of GI clinic." So I think that implies that I would have told him to call the next day, let them know that you were seen in the emergency room and that outpatient endoscopy is indicated and that you need to be seen with GI clinic.
In terms of the scheduling, the residents are not really the ones who deal with the scheduling. It's more of the administrative people at the V.A., so I don't know how that works.
Q. Based on everything you see, it's your understanding that you are telling him, "I'm going to refer you to this. The computer knows I'm referring

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you to this, but you are the one that has to call to make the appointment"?
A. Yeah, and I think that at the V.A., you don't really -- I mean, everything needs to go through the computer. So I don't know that it goes through the computer, and then Lloyd Ralph sees it and then contacts the patient, in addition to the patient calling the clinic. I just always, to be extra sure, give the patient the number of the clinic so they can make contact on their end.
MR. MEDINGER: I think that's it.
MR. SMITH: No questions from the government, and we'll read and sign.
(Signature having not been waived, the deposition of ETHYL D. WELD, M.D. was concluded at 3:37 p.m.)

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ACKNOWLEDGEMENT OF DEPONENT
I, ETHYL D. WELD, M.D., do hereby acknowledge that I have read and examined the foregoing testimony, and the same is a true, correct, and complete transcription of the testimony given by me, and any corrections appear on the attached Errata sheet signed by me.

_____ _____
(DATE) (SIGNATURE)

CERTIFICATE OF SHORTHAND REPORTER - NOTARY PUBLIC

I, Rachel R. Hilker, commissioned as Rachel R. Hilker, the officer before whom the foregoing proceedings were taken, do hereby certify that the foregoing transcript is a true and correct record of the proceedings; that said proceedings were taken by me stenographically and thereafter reduced to typewriting under my supervision; and that I am neither counsel for, related to, nor employed by any of the parties to this case and have no interest, financial or otherwise, in its outcome.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 7th day of October 2011.

My commission expires:
September 20, 2013

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NOTARY PUBLIC IN AND FOR THE
STATE OF MARYLAND

ERRATA SHEET

IN RE: Goodie v. The United States of America

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